HEALTH AND HUMAN SERVICES
REGULATION AND LICENSURE
DIVISION OF INVESTIGATION
P.O.BOX 95164
LINCOLN, NEBRASKA 68509-5164

REPORT BY INSURERS

Section 1: REPORTING ENTITY - Complete all items.

Name of Insurance Company: _____

Address: _____

_____

Telephone No: _____

Section 2: IDENTIFYING INFORMATION - Complete all items for the person being reported if information requested is known.

Name: _____ Work Telephone No: _____
(First) (M.I.) (Last)

Nebraska License No: _____

Work Address: _____

License Field: _____

_____
(City) (State) (Zip)

Social Security No: _____ Date of Birth: _____
(OPTIONAL - see back for instructions)

Section 3: ACTION BEING REPORTED - Complete all items in Parts A, B or C that apply. If additional space is needed, please attach pages to this form.

Part A - Regulatory Violation

1. Describe the suspected violation by stating the act(s), omission(s), or conduct that has occurred:

2. Identify the statute or regulation (if known) you believe to have been violated:

3. Enter the date(s) on which the act(s), omission(s), or conduct occurred:

_____

4. Specify where the act(s), omission(s), or conduct occurred:

   Location Name: _____

   Address: _____

   _____

   Telephone No: _____

5. Describe how the act(s), omission(s), or conduct that occurred:

6. Describe any injury, illness, damage, or other loss or detriment that resulted from the act(s), omission(s), or other conduct being reported:

7. List all persons who were present at the time of the act(s), omission(s), or conduct and would have firsthand knowledge of the suspected violation:

Name	Title	Address	Telephone #

Part B - Adverse Action Affecting Coverage

1. Indicate the type of action taken by checking all items that apply:

   a. ☐ Denial of Coverage
   b. ☐ Refusal to Renew Coverage
   c. ☐ Coverage Terminated or Cancelled
   d. ☐ Coverage Limited, Reduced, or Modified
   e. ☐ Premium/Rate Increased
   f. ☐ Other (Specify): _____

2. Describe the act(s), omission(s), or conduct which lead to adverse action affecting coverage:

3. Enter the Date of the Adverse Action: _____;
   Effective Date: _____; and Duration of the Adverse Action: _____

4. Specify where the act(s), omission(s), or conduct leading to the action occurred:

   Location Name: _____

   Address: _____

   _____

   Telephone No: _____

5. Enter the date(s) on which the act(s), omission(s), or conduct occurred:

   _____

6. Describe how the act(s), omission(s), or conduct occurred:

7. Describe any injury, illness, damage, or other loss or detriment which formed the basis for action affecting coverage:

8. List all patients, clients, or other persons who were the subject(s) of the act(s), omission(s), or conduct which lead to action affecting coverage:

Name	Address	Telephone #

9. List all persons who were present at the time of the act(s), omission(s), or conduct or and would have firsthand knowledge of the same:

Name	Title	Address	Telephone #

Part C - Payments

E Insurers who are reporting persons who are subject to the National Practitioner Data Bank requirements need not complete this Section but must complete the Nebraska Supplement.

E Insurers who are reporting persons who are not subject to the National Practitioner Data Bank must complete this Section.

1. Indicate the type of payment made by checking the item that applies:

   a. ☐ Adverse Judgment
   b. ☐ Settlement
   c. ☐ Award
   d. ☐ Other (Specify): _____

2. Describe the act(s), omission(s), or conduct which gave rise to a claim:

3. Enter the following information:

   a. Date of Judgment, Settlement, or Award: _____
   b. Payment Date: _____
   c. Payment Amount: $ _____
   d. Payment terms and conditions, if any:

   _____

4. State where the act(s), omission(s), or conduct occurred:

   Location Name: _____

   Address: _____

   _____

   Telephone No: _____

5. Describe how the act(s), omission(s), or conduct occurred:

6. Describe any injury, illness, damage, or other loss or detriment that resulted in the payment being made:

7. List all patients, clients, or other persons to whom or for whose behalf payment was made:

Name	Address

8. List all persons who were present at the time of the act(s), omission(s), or conduct which resulted in a payment and who would have firsthand knowledge of the same:

Name	Title	Address	Telephone #

9. When payment results from a court action or claim having been filed with a court or other adjudicative body, complete the following items:

a. Name of court or adjudicative body: _____

b. Address: _____

_____

c. Case No: _____ Date of Judgment or Order (if any): _____

Section 4: REPORTING ENTITY - Complete all items.

Name of person completing report:

_____ Title: _____

(First) (M.I.) (Last)

Address: _____

_____

_____ _____

(Signature) (Date)

Instructions for reporting social security number:

Disclosure of the social security number should be made only if obtained by you in accordance with Section 7 of the Privacy Act of 1974. Your disclosure is voluntary and failure to provide the number will not subject you to penalty. The purpose for the request is to assist in distinguishing between persons who have the same or similar names for the Department's recordkeeping and implementation of Neb. Rev. Stat. §71-168, 71-168.02, 71-1,198 to 71-1,205, and 172 NAC 5, which requires you to file a report with the Department concerning health care professionals when certain actions or events occur. The report you file is subject to review by the applicable licensing board and Department and Attorney General staffs for purposes of enforcement of Nebraska licensing laws. Information is otherwise confidential and made available only according to Neb. Rev. Stat. §71-168.01 in the same manner as complaints and investigative files of the Department or as may otherwise be provided by law.